Brecon Medical Centre

Dering Lines, Brecon, Powys, LD3 7RA

Defence Medical Services inspection report

This report describes our judgement of the quality of care at Brecon Medical Centre. It is based on a combination of what we found from information provided about the service, patient feedback and interviews with staff and others connected with the service. We gathered evidence remotely in line with COVID-19 restrictions and guidance and undertook a short visit to the practice.

Overall rating for this service	**Good**	
Are services safe?	**Good**	
Are services effective	**Good**	
Are service caring?	**Good**	
Are services responsive to people's needs?	**Good**	
Are services well-led?	**Good**	

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Summary

About this inspection

We carried out an announced comprehensive inspection of Brecon Medical Centre on 7 February 2019. The practice received a rating of requires improvement overall, with a rating of inadequate for the safe key question and requires improvement for the effective, caring and well-led key questions. Responsive was rated as good.

A copy of the previous inspection reports can be found at:

https://www.cqc.org.uk/what-we-do/services-we-regulate/defence-medical-services#medical

We carried out this announced follow up comprehensive inspection on 8 and 9 July 2021. The first day we gathered our evidence remotely and the lead inspector visited the service on the second day. The report covers our findings in relation to the recommendations made and any additional improvements made since our last inspection.

As a result of this inspection the practice is rated as good overall in accordance with CQC's inspection framework.

Are services safe? – good

Are services effective? – good

Are services caring – good

Are services responsive to people's needs? – good

Are services well-led? - good

The CQC does not have the same statutory powers with regard to improvement action for the Defence Medical Services (DMS) under the Health and Social Care Act 2008, which also means that the DMS is not subject to CQC's enforcement powers. However, as the military healthcare Regulator, the Defence Medical Services Regulator (DMSR) has regulatory and enforcement powers over the DMS. DMSR is committed to improving patient and staff safety and will ensure implementation of the CQC's observations and recommendations.

This inspection is one of a programme of inspections that the CQC will complete at the invitation of the DMSR in their role as the military healthcare Regulator for the DMS.

At this inspection we found:

- The practice was well-led and the leadership team demonstrated they had the vision, capability and commitment to provide a patient-focused service and consistently sought ways to develop and improve.

- An inclusive whole-team approach was supported by all staff who worked collaboratively to provide a consistent and sustainable patient-centred service.
- There was an open and transparent approach to safety. An effective system was in place for managing significant events and staff knew how to report and record using this system.
- The arrangements for managing medicines, including obtaining, prescribing, recording, handling, storing, security and disposal minimised risks to patient safety. There was an effective and holistic approach to the monitoring of patients on high risk medicines.
- The practice worked collaboratively with internal and external stakeholders, and shared best practice to promote better health outcomes for patients.
- The healthcare governance workbook was well-developed and captured a wide-range of information to illustrate how the practice was performing.
- Quality improvement activity was embedded in practice, including various approaches to monitor outputs and outcomes used to drive improvements in patient care.
- The practice pro-actively sought feedback from patients which it acted on. Feedback showed patients were treated with compassion, dignity and respect and were involved in care and decisions about their treatment.

We identified the following notable practice, which had a positive impact on patient experience:

- The practice provided emergency department doctors at Grange University Hospital, Cwmbran, with training on the clinical management of exertional heat illness. The aim was to support NHS clinicians to better understand the demands of military training and to discuss best practice guidelines for assessment and management, including recent updates to the military climatic injury prevention policy. It is anticipated the link between local NHS services and military clinicians can be maintained to ensure military patients continue to receive the best clinical care in both defence and NHS settings.
- The practice was committed to meeting the principles of the Equality Act 2010, including safeguarding people with protected characteristics. For example, the age of the over 40 health screen was lowered to over 25 for the BAME patient population because of recognised risks associated with COVID-19. Patients meeting the criteria were offered a health check. This meant all patients over the age of 25 from the BAME population received a health screen. In addition, the practice made contact with the military LGBT+ network and received training to better understand the challenges faced by transgender patients in order to improve the service provided. As a result, the practice developed a standard operating procedure regarding preferred pronouns. Patient feedback suggested staff were caring, empathic and comfortable with engaging in sensitive discussions, and understood the specific health needs of transgender patients.

The Chief Inspector recommends:

That all staff working at the practice complete mandatory training.

Dr Rosie Benneyworth BM BS BMedSci MRCGP

Chief Inspector of Primary Medical Services and Integrated Care

Our inspection team

The inspection team was led by a CQC inspector and comprised specialist advisors including a primary care doctor and practice manager. CQC's Administrative Support Officer for the DMS team interviewed patients. We were unable to secure a physiotherapist specialist advisor for the inspection, so the Primary Care Rehabilitation Facility (PCRF) was not inspected as part of the inspection. The previous inspection identified no concerns or risks in relation to the service provided by the PCRF.

Background to Brecon Medical Centre

Brecon Medical Centre provides a primary health care, occupational health and rehabilitation service to a military service population (mainly army) of 433 registered patients from the age of 18. The patient population is drawn from a range of units over a wide geographic area. The main unit is the Infantry Battle School (IBS) with approximately 3, 500 students passing through the IBS each year. In addition, the medical centre supports over 300 reserves and service personnel who use the Sennybridge Training Area (SENTA). The practice does not provide primary health care for families or civilian Ministry of Defence employees.

A PCRF is located within the medical centre and provides a physiotherapy and rehabilitation service. As there is no dispensary at the practice, medicines are dispensed from a local pharmacy.

The practice is open from 08:00 to 18:30 Monday to Friday. From 18:30 hours midweek and at weekends and public holidays, patients are directed to contact NHS 111.

Developments during the COVID-19 pandemic

The practice supported the NHS during the pandemic with the practice manager deployed in January 2021 for two months to support an NHS COVID-19 ward. Other military staff members remained on 48 hrs notice to deploy during the pandemic. In addition, the practice supported defence during by establishing a Defence COVID-19 Bedding Down Facility (DCBDF) by re-opening a ward that was previously part of the medical centre. The DCBDF provided 24-hour medically supervised care to military personnel with suspected or confirmed COVID-19 who did not require hospitalisation but were too unwell or unsuitable to return to their usual accommodation. The facility was staffed by practice staff and could admit patients within two hours of notification.

The staff team at the time of the inspection

Doctors	Military Senior Medical Officer Two Civilian Medical Practitioner (CMP)
Nurses	Military Senior Nursing Officer Practice nurse – Band 6 Practice nurse – Band 5
Practice manager	One - military
PCRF	Civilian physiotherapist – Band 7 (Vacant post for part time Physiotherapist Band 6)
Administrators	Two – E1 and E2

Are services safe?

We rated the practice as good for providing safe services.

Following our previous inspection, we rated the practice as inadequate for providing safe services. We found inconsistencies in processes to keep patients safe including gaps in infection prevention and control (IPC); medicines management; significant event reporting; safeguarding vulnerable patients and the management of referrals.

At this inspection we found the recommendations we made had been actioned.

Safety systems and processes

- The SMO was the safeguarding lead and one of the CMPs the deputy lead. All staff had completed safeguarding training at a level appropriate to their role. The child and adult safeguarding policy was reviewed in June 2021. Safeguarding reporting flowcharts for working hours and out-of-hours were displayed in prominent areas of the premises and included the contact details for local safeguarding agencies. Staff interviewed during the inspection were aware of the policy, including how to report a safeguarding concern.
- Alerts were applied to clinical records to identify patients considered vulnerable. A monthly search of DMICP (electronic patient record system) was undertaken to ensure the register of vulnerable patients held on DMICP was current. The search was checked against the previous month's search to ensure no vulnerable patient had moved out of the practice without the team being made aware, Patients on the register were reviewed at the monthly 'complex patient management' meeting, which was attended by the SMO, SNO, CMP and practice manager. A standard operating procedure (SOP) was in place to guide structuring the meetings. The vulnerable patient's register and individual patient records were updated to reflect the outcome of the discussion. Vulnerable patients were also discussed at the health committee meetings, regularly held for the various units. The practice's search for vulnerable patients was cross-matched with the registers held by the units to ensure all vulnerable service personnel were known and being supported.
- The practice had strong links with the Infantry Battle School (IBS) welfare team who informed the SMO if any safeguarding referrals were made to statutory services for a family members of service personnel. The practice had also established external links with the local police and the SMO had sent a letter to the local GP practices who looked after family of their patients. As a result of these actions, the practice had had some safeguarding referrals highlighted to them by NHS GPs. This meant the practice could take a holistic approach to the care of the patient. One of the practice nurses maintained links with the local safeguarding board by attending regular board-led training.
- Staff received chaperone training in June 2021. Only healthcare professionals were used as chaperones and a detailed chaperone SOP was in place that included the clinical codes to be applied on DMICP. Information advertising the availability of chaperones was displayed in all clinical rooms and included in the practice leaflet.

- The full range of recruitment records for permanent staff was held centrally. However, the practice could demonstrate that relevant safety checks had taken place at the point of recruitment, including a Disclosure and Barring Service (DBS) check to ensure staff, including locum staff, were suitable to work with vulnerable adults and young people. DBS checks were renewed every five years. The practice manager completed monthly checks of the professional registration status of clinical staff and conducted a six monthly check of DBS certificates for all staff, including locums. All staff had Crown indemnity. The SNO monitored the vaccination status of staff.
- The IPC lead for the practice and three other staff had completed IPC link practitioner training. Hand washing training was undertaken in July 2021. Various COVID-19 specific training sessions were held from March to May 2020, mainly in relation to the opening of the Defence Covid-19 Bedding Down Facility. The IPC lead attended the quarterly IPC regional forums with the aim to ensure the practice was meeting the IPC requirements associated with operating in a COVID-19 environment.
- Patients presenting at or contacting the practice with potential COVID-19 were assessed and tested in a tent adjacent to the building. A separate tent was used for the putting on and taking off of personnel protective equipment (PPE). Units and service personnel new to the camp were required to isolate for two weeks.
- An IPC audit for the premises was completed in January 2021 and the practice achieved a compliance score of 95%. In response to actions identified, a statement of need (SON) was submitted for improvements to the kitchen and for the installation of clinical curtain rails. This work was due to start in August 2021.
- In accordance with the cleaning contract, a cleaning schedule was in place. The cleaning team worked to the Defence Primary Health Care (DPHC) cleaning standards and managerial checks were completed weekly by the practice manager who was the cleaning lead for the practice. Any issues identified were discussed with the cleaner and resolved. Any practice requests for deep cleaning due to COVID-19 were directed to the cleaning manager who responded promptly. Patients we interviewed as part of the inspection described a very clean environment and how staff were conscientious about the use of PPE since the start of the pandemic.
- Arrangements were in place for the management of clinical waste including a waste log and consignment notes. Clinical waste was stored in a lockable waste bin in a secure cage outside the medical centre. An IPC clinical waste audit was completed in May 2021 and a pre-acceptance audit in April 2021.

Risks to patients

- Staff we spoke with said staffing levels were adequate to meet the needs of the patient population. Patients we interviewed as part of the inspection supported this view. We found there was a good clinical skill mix and balance between military and civilian clinicians. The SMO was deployed abroad at the time of the inspection and maintained communication with the practice to ensure continuity. Staffing was reviewed at the monthly management meetings. An induction programme had recently been developed for locum doctors. A centralised staff rota was in place and was managed by the

practice manager. This supported the team with planning leave and arranging cover for planned absences.

- The SNO was trained in intermediate life support so acted as the resuscitation lead for practice. The staff team was up-to-date with training in emergency procedures, including basic life support, anaphylaxis and the use of an automated external defibrillator. The practice was equipped to deal with medical emergencies. Emergency medicines and equipment were monitored regularly, and records maintained of the checks.
- In-service training to recognise the deteriorating patient had been provided for staff in May 2021 and heat injury training in July 2021. Staff were familiar with the major incident plan for the camp.
- CCTV was installed to ensure reception staff could observe patients in the waiting area.

Information to deliver safe care and treatment

- In the event of a local fixed network outage, staff had the option to connect laptops to the practice WIFI so could continue to access DMICP. With a more widespread outage staff referred to the business continuity plan and just see emergency patients. Packs of paper forms were available to document consultations which would be later scanned onto DMICP. Paper forms for reporting significant events and ASER and safeguarding concerns were also available. Clinic lists were routinely printed for the following day.
- An SOP was in place to ensure summarisation of patients' records was undertaken in a safe and timely way. Patients registering at the practice completed a new patient questionnaire, which was submitted to the nursing team for scrutiny and summarising. This process identified any actions that required follow up. Although new patients were routinely offered an appointment, staff advised us that the uptake was low. A DMICP search in May 2021 showed all clinical records had been summarised.
- Formal peer review of clinician record keeping was undertaken every six months to ensure compliance with the General Medical Council's standards on good medical practice. An audit of the nurses' clinical records was facilitated by the SNO and last took place in May 2021. The outcome of the audit was discussed with individuals and actions agreed. Findings were discussed at the governance meetings for shared learning. Daily 30-minute informal post-lunch meetings were held for clinical case discussion between doctors, nurses and the physiotherapist to encourage collaborative working.
- Three health boards were involved with the processing of specimens with the majority processed by Aneurin Bevan University Health Board. To ensure safe coordination of specimens at the various healthcare locations, the practice worked to detailed guidance; a samples administration process SOP and a test request SOP. Because of previous issues and risks with the processing of specimens, the documentation for all specimens sent was photocopied and held until results returned to cross-reference the tests requested. Any anomalies noted were followed up and documented in the lab folder, samples log and on the DMICP record. Results were checked by duty nurse each morning. A tracker was maintained to monitor delays and any issues with the

laboratories. The duty doctor reviewed all pathology results on DMICP each morning. The nursing staff also carried out an audit to check the doctor had reviewed the results within the agreed timeframe. Patients were informed of the outcome of tests by telephone or contacted to make an appointment with a doctor.

- The process for the management of both internal and external referrals had been strengthened. An audit in 2018/19 showed the management of referrals was weak with just 40% of referrals tracked. The referrals tracker had since been refined, administrative staff trained and the coding of referrals introduced. An audit of the referral tracker in 2019/20 showed its use had increased to 80%. The SMO introduced a referrals management SOP. In 2021, a further audit showed the use of the referral tracker at 100% and coding at 50%. An email was sent to clinicians to remind about applying coding and which code to use.
- Clinicians sent referral tasks to individual administrators. We highlighted the risks with this approach, notably the absence of that individual. The SNO confirmed the practice would change to using a group email box. The development of the referral tracker including the use of coding had been identified and reported as a quality improvement project.

Safe and appropriate use of medicines

- The SMO had the overall lead for medicines management with one of the practice nurses responsible for day-to-day management of medicines. The practice did not dispense patient's medicines and a nominated pharmacy in Brecon was used. Medicines held at the practice included emergency medicines, vaccines and stock medicines. They were stored in a temperature controlled locked medical storeroom. Temperature checks of the both the medical store and medicines fridge were undertaken and recorded each day.
- A register was maintained to track controlled drugs (medicines with a potential for misuse). We observed a safe process was in place for accessing the controlled medicines cupboard, which included the signature of two members of staff. The keys were stored in a locked cabinet in the SNO's office. Out of date controlled drugs were stored in a locked box. The nurses checked the controlled drugs monthly and the duty Field Officer participated in the check each quarter.
- Patient Group Directions (PGD) had been developed to allow the practice nurses to administer medicines in line with legislation. These were up-to-date and signed by the SMO. All the nurses had completed training in PGD administration. A PGD mandatory audit was completed in April 2021 and showed 100% compliance.
- The doctors had considered the characteristics of a high risk medicine (HRM) and agreed on a definition for the practice; a medicine that requires any form of monitoring, either a physical review or blood test, a medicine with grading implications impacting the patient's job role or a medicine that has a significant long term side effects. The list of HRMs was included in the practice HRM SOP. Valproate (treatment for epilepsy and a mood stabilising medicine) was included on the weekly HRM search to check pregnancy prevention information for women able to have children. The practice

reported no patients were prescribed valproate, which was verified by our searches of DMICP.

- Patients prescribed an HRM were discussed at the monthly complex patient meeting and the HRM register updated accordingly. Although most patients were compliant with monitoring, a monthly search was run to identify those with overdue blood tests who needed to be recalled. If the results of monitoring were not visible to the secondary care consultant then they were sent by the practice nurse. An HRM audit undertaken in May 2021 demonstrated good results for the practice in its management of HRMs. Fifty per cent of patients did not have a shared care agreement (SCA) and the audit acknowledged this related to national variability in secondary care practices. For example, the All Wales Medicines Strategy Group guidance on endocrine management of gender dysphoria in adults supported the primary care doctor as the prescriber for transgender patients on long term therapy.
- Our review of clinical records for patients prescribed an HRM showed clinical care was safe with effective safeguards in place to ensure patients were monitored. The most recent search identified 13 patients who were prescribed an HRM. Each patient had an alert indicating the medicine prescribed and the monitoring requirements. The search also identified if a medicine was a one-off prescription that did not require monitoring. We reviewed in detail a small sample of the records for patients prescribed HRMs. Hospital only prescribed medicine was documented appropriately with correct coding and alerts applied. Alerts and coding were also in place for patients with a shared care agreement with secondary care.
- An audit of antibiotic prescribing was undertaken in June 2021. The aim of the audit was to determine if the practice was in line with the Wales National Prescribing Indicators 2020-21, in relation to the prescribing of broad spectrum antibiotics (referred to as the 4C antimicrobials). The practice met the audit standard of an overall reduction in the prescribing of 4C medications. In addition, a reduction in overall antibiotic prescribing was identified when compared to audits from previous years.

Track record on safety

- The practice manager was the lead for health and safety. Policies and risk assessments pertinent to the practice were in place, including for clinical rooms, the building, substances hazardous to health and new and expectant mothers. A COVID-19 risk assessment was in place to reflect changes in working practices. This was supported by an induction pack for COVID-19 that outlined the service changes. A risk register, retired risks and an issues log were in place. All risk assessments were reviewed every six months and the risk register was reviewed at the monthly management meeting.
- Processes were in place and up to date for the checking of electrics, equipment and water safety. Health and safety monthly workplace inspections were undertaken with the most recent in June 2021. The practice lead for fire safety carried out a range of weekly and/or monthly checks, including checks of fire doors and the fire alarm system. Staff were up-to-date with fire safety training undertaken as part of the DPHC mandated training policy. The fire risk assessment was due for review in September 2021.

- An emergency alarm system was in place in all clinical areas. The system was tested each month and recorded by the practice manager.

Lessons learned and improvements made

- All staff had access to the local SOP and electronic organisational-wide system (referred to as ASER) for recording and acting on significant events and incidents. An ASER tracker was maintained on the healthcare governance (HCG) workbook including any actions required and the completion date. The HCG workbook is the system used in DPHC services to bring together a range of governance activities, including the risk register, significant events tracker, lessons learnt log, training register, policies, meetings, quality improvement and audit.
- From interviews with staff and evidence provided, it was clear there was a culture of reporting and learning from incidents. Both clinical and non-clinical staff provided examples of incidents reported through the ASER system, including improvements made as a result of the outcome of investigations. As an example, a delay in referring a patient for a two week wait referral was identified early and treated as a never event (preventable serious incident). Staff described the learning outcomes and the changes made to practice as a result, including revision of the referral SOP and staff training in never events. ASERs were discussed at practice and HCG meetings.
- An ASER report from June 2020 to May 2021 indicated seven significant events were reported during the timeframe with the action taken and learning identified. Two positive practice ASERs were submitted (referred to as purple ASERs).
- One of the practice nurses was the lead for patient safety alerts. Alerts were received from the DPHC via the group mailbox and by checking the Medicines and Healthcare products Regulatory Agency website. Alerts were checked and if relevant emailed to clinicians. They were also discussed at practice meetings.

Are services effective?

We rated the practice as good for providing effective services.

Following our previous inspection, we rated the practice as requires improvement for providing effective services. We found inconsistencies in processes to ensure effective services for patients including gaps in chronic disease management; mental health coding; quality improvement activity; staff induction and mandatory training.

At this inspection we found the recommendations we made had been actioned.

Effective needs assessment, care and treatment

- Processes were in place to support clinical staff to keep up to date with developments in clinical care including NICE (National Institute for Health and Care Excellence) guidance, the Scottish Intercollegiate Guidelines Network (SIGN), clinical pathways, current legislation, standards and other practice guidance. Various forums were established for this including the patient injury management meetings, nurses' meetings, healthcare governance (HCG) meetings and complex patient meetings.
- Staff were kept informed of clinical and medicines updates through the DPHC newsletter circulated to staff each month. Two weekly regional COVID-19 SKYPE meetings had been used to cascade changes regarding the policy direction of service delivery. Thirty minutes was set aside at end of clinic each day for clinical discussions.
- The practice had supported local units during COVID-19. For example, the camp isolation facility had been monitored and service personnel in isolation supported with input from practice clinicians. The practice participated in the weekly Infantry Battle School (IBS)-led COVID-19 meeting to share updates and discuss current issues.
- During a local outbreak of COVID-19 in October 2020 virtual meetings were held between the practice, IBS, local health board and public health to coordinate the response to the outbreak. Clearance was given to the practice through this forum to perform pillar 1 swab testing.

Monitoring care and treatment

- One of the doctors was the lead for chronic disease and, along with the nursing team, had developed a chronic disease management protocol. The protocol supported an extensive range of chronic disease SOPs which took into account the DMICP chronic disease templates, NICE and DPHC guidance. It included clear guidance for doctors and nurses, including monitoring/review frequency and the templates to use.
- The practice provided us with the following chronic disease data:
    - There were five patients on the diabetic register. For all five patients, the last measured total cholesterol was 5mmol/l or less which is an indicator of positive cholesterol control. For all patients, the last blood pressure reading was 150/90 or less which is an indicator of positive blood pressure control.

  - There were 18 patients recorded as having high blood pressure. Seventeen patients had a record for their blood pressure taken in the past nine months. Fourteen patients had a blood pressure reading of 150/90 or less.
  - There were six patients with a diagnosis of asthma. All had an asthma review in the preceding 12 months using the DMICP asthma template.

- Through a search set up within DMICP to monitor recall, the nursing team carried out monthly checks to identify and follow up patients who were due testing or a review. If patients failed to respond, they were telephoned, emailed and/or send a text. As a last resort, the Chain of Command would be advised and would remind the patient to attend the medical centre.
- In line with the April 2020 DPHC directive, routine audiometry had ceased. The practice was awaiting further guidance as to when routine audiometry could be resumed. Seventy nine percent of patients' audiometric assessments were in date (within the last two years).
- Step 1 of the DPHC mental health pathway was delivered by the doctors at the practice. Prescriptions for antidepressants were not kept on repeat to ensure the patient maintained clinical contact with the practice even if they were receiving specialised mental health support from with Department of Community Mental Health (DCMH). Mental health coding was based on the clinician's decision and reflected the patient's diagnosis. For all patients considered vulnerable due to their mental health, a front page alert was added to their records and the Chain of Command informed of any restrictions in accordance with the vulnerable patient management and safety critical SOPs. The practice routinely involved the DCMH at an early stage. Access to psychological intervention was through the DCMH and criteria for referral was clinician dependent.
- Service personnel in the isolation block due to COVID-19 received daily telephone calls from the welfare team to assess their wellbeing, including the need for mental health support. Some patients required more support, particularly those in isolation who had been referred to secondary care, including a two-week-wait referral.
- We looked at a broad range of patient records on DMICP including the records for patients with asthma, diabetes, high blood pressure and a mental health diagnosis. They showed effective and thorough clinical management. All records indicated the Joint Medical Employment standard (JMES) was reviewed to accurately reflect the patient's ability to deploy and be employed in their normal duties.
- The practice took a pro-active approach to identifying and making improvements to the service. For example, the previous CQC inspection identified deficits with the management of referrals. Since then, three audits had been undertaken and improvements to the process made as a result of each audit. An annual audit planner was established for 2021 that included the topic and who would undertake the audit. A log of audits completed from 2018 to 2021 was maintained on the HCG workbook. It identified how many times the audit had been repeated and when the next repeat audit was due. Clinical audit topics were relevant to the patient population and their clinical needs. For example, an audit to identify ethnic minority patients above the age of 25 at risk from COVID-19 to offer additional health checks was reported as a quality improvement project. The sample of clinical audits we looked at followed a recognised

structure to guide with audit planning, such as that identified by the Royal College of General Practitioners.

- Clinicians participated in the Practice Based Small Group Learning (PBSGL) recently commenced across the DPHC south Wales area. Based on the established PBSGL programme endorsed by NHS Education for Scotland, it involved virtual clinical case discussion. The most recent session was held in May 2021 and looked at gastrointestinal case studies.

Effective staffing

- A generic induction was in place for the practice with a detailed description of roles and responsibilities for each staff role. All staff had a refresher induction to the practice in early 2021, which included COVID-19 specific guidance. Mandatory training was recorded on the staff database and monitored by the practice manager. All staff had protected time to complete mandatory training. Compliance with mandatory training was mostly good although one member of staff had a large number of training courses which were out-of-date for completion and had been for some time. Staff appraisals were up-to-date.
- Clinical supervision was undertaken in the form of peer review involving an audit of individual clinician's consultation records. The daily informal case discussion time was used to ensure clinicians were working effectively and in line with current practice. A plan was in place for regional clinical supervision for nurses.
- Staff advised us that continual professional development (CPD) was encouraged by the leadership team. Clinical staff had protected time to undertake training and audit to support with CPD and revalidation. As part of annual appraisal, a training needs analysis was undertaken, and objectives set on the basis of training required. Training was available through various internal and external sources. As the practice was a Powys based primary care practice, clinicians could access training via Powys Teaching Health Board.
- The practice manager has completed the DPHC practice management course, DMICP administrator course and Institute of Safety and Health course. One of the practice nurses had completed the asthma diploma and a minor illness course and another practice nurse was undertaking a diabetes distance learning module. Two of the nurses had completed yellow fever online update to retain the practice's yellow fever centre status. All the nurses had completed the required course for immunisation. The SMO had completed the General Duties Medical Officer's (GDMO) supervisors' course. A GDMO is a junior army doctor attached to a field unit before commencing higher level specialist training.

Coordinating care and treatment

- The SMO or SNO attended the four regular unit health committee meetings at which the health and care of vulnerable and downgraded patients was reviewed. These meetings continued during COVID-19 in a virtual format. The practice's vulnerable persons searches were cross referenced with the vulnerable persons' registers held by

the units to ensure all vulnerable service personnel were known and being managed appropriately.

- The practice had good links with local NHS services including the two health boards. These links had supported the practice with securing timely access to COVID-19 vaccinations for staff and patients. The practice identified a risk with not receiving information in a timely way from the NHS so raised a business case and were successful in securing funding for an NHS laptop. This had given clinicians real time access to clinical hospital records at Aneurin Bevan University Health Board including the status of urgent referrals, pathology results and the results of scans. There had been some issues with Welsh NHS waiting times but every effort had been made by practice to mitigate and minimise this.
- The practice provided emergency department doctors at Grange University Hospital, Cwmbran, with training on the clinical management of exertional heat illness. The aim was to support NHS clinicians with better understanding the demands of military training and to discuss best practice guidelines for assessment and management, including recent updates to military climatic injury prevention policy.
- The practice worked closely with other DPHC facilities locally and further afield. Patients requiring specialist medicals were referred to St Athan Medical Centre. For example, St Athan Medical Centre provided access to COVID-19 vaccinations for service personnel due to deploy. Where patients had been working from home or isolating away from the area, the nursing team have been involved in coordinating care delivery from other practices. Patients we interviewed as part of the inspection described timely access when referred to either internal or external secondary care services.
- For patients leaving the military, pre-release and final medicals were offered. During the pre-release phase, the patient received an examination and a medication review. A summary print-out was provided for the patient to give to the receiving doctor, and a letter if the patient was mid-way through an episode of care. Patients were also made aware of the Veterans Health Service and, if appropriate, the Veterans Mental Health Transition, Intervention and Liaison Service (TILS). The practice had links with local veterans' charities and the SMO had met with one of the charities to promote a seamless transition for patients. If appropriate, patients were discussed at the monthly complex patient meeting and actions identified to assist their transition to civilian life. Female patients leaving the services for the NHS were notified to Cervical Screening Wales.
- Evidence was provided during the inspection of a comprehensive handover of patients between services when patients had specific needs. For example, the practice made substantial efforts to track down the doctor of a patient who was posted during COVID-19 to ensure a full handover in relation to a condition requiring treatment.

Helping patients to live healthier lives

- One of the practice nurses was the lead for health promotion. The health promotion strategy was based on national initiatives and took account of the patient population need, including in relation to their occupation. For example, a display for heat and cold

injuries was rotated depending on the season. Displays and leaflets to promote health and awareness were visible throughout the building, including information about skin cancer, diabetes and smoking cessation. Participation at health fairs has been limited by COVID-19 but the practice had provided a presentation on smoking cessation services via a virtual health fair. Two of the nursing team had completed smoking cessation training. Patients we interviewed as part of the inspection said the practice provided a lot of information about how to look after your health, including mental health.

- The SNO was the lead for sexual health and had completed required training for the role. Patients were treated at the practice. For more complex conditions, they were signposted to sexual health services in the local area. Patients could also be referred to the military sexual health service in Birmingham. The practice recently received a training session from the nominated regional sexual health link nurse. Local sexual health services were advertised within the practice and condoms were available along with sexual health leaflets.
- SOPs were in place for monthly screening searches and recall. Eligible patients were identified by coding on their records. A practice nurse had the lead for cervical screening which they monitored and managed in conjunction with Cervical Screening Wales. Cervical smears were not carried out at practice due to the low number of eligible females in the patient population. Twenty-one patients were eligible for cervical screening of which 20 had a cervical smear in the last 3-5 years which represented an achievement of 95%. The NHS target was 80%.
- The monthly searches undertaken for bowel, breast or abdominal aortic aneurysm screening in line with national programmes showed no patients were eligible. As a result of the COVID-19 pandemic and in accordance with DPHC directive, routine immunisations had ceased and remained so at the time of the inspection. Only operationally essential vaccinations were administered. The vaccination statistics were identified as follows:
    - 99 % of patients were in-date for vaccination against diphtheria.
    - 99% of patients were in-date for vaccination against polio.
    - 97% of patients were in-date for vaccination against hepatitis B.
    - 97 % of patients were in-date for vaccination against hepatitis A.
    - 99% of patients were in-date for vaccination against tetanus.
    - 95.6% of patients were in-date for vaccination against MMR.
    - 100% of patients were in-date for vaccination against meningitis.
- Vaccination searches were undertaken each month and patients recalled if required. COVID-19 had reduced the number of vaccines delivered. Patients were identified for the flu vaccine using condition searches within DMICP and were then sent invites when flu vaccines were available. We were advised that at the end of the last flu season (April 2021) all entitled personnel had received the flu vaccination.

Consent to care and treatment

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making. They had a good understanding of the Mental Capacity Act (2005) and how it would apply to the population group. The SNO provided virtual mental capacity training to the staff team in June 2021 including criteria for assessing capacity and case studies.
- A consent and chaperone audit was undertaken in April 2021 and it showed coding had improved since the previous audit. The audit showed 85% compliance. Consent Read codes (standardised clinical coding system) had been added to the system to increase routine use.

Are services caring?

We rated the practice as good for providing caring services.

Following our previous inspection, we rated the practice as requires improvement for providing caring services. This was because the privacy and dignity for patients was not consistently maintained.

At this inspection we found the recommendations we made had been actioned.

Kindness, respect and compassion

- Patients interviewed as part of this inspection described a staff team who were kind and provided individualised care. This view was reflected in the feedback the practice received about the service through the patient focus groups, internal survey and regional patient survey.
- During a COVID-19 outbreak at the barracks, the practice provided patients in isolation with general information through WhatsApp. We were provided with a number of examples of how the staff went over and above what was required of them in providing patients with compassionate care.
- The practice promoted an information network (known as HIVE) available to all members of the service community and provided a range of information to patients who had relocated to the base and surrounding area.

Involvement in decisions about care and treatment

- Feedback from the regional-wide patient survey rated the practice as either excellent or good for providing information and effectively addressing their healthcare needs. Patients we interviewed expressed a similar view.
- We were advised patients usually identified themselves as having a caring responsibility, often through the new patient registration form or when the welfare team shared this information with the practice. Alerts were added to clinical records to identify carers so they could be offered a carers park, flexibility with appointments and the COVID-19 and flu vaccines. A carers SOP was in place and a carer's code was added to the patient's record. The needs of the small number of carers identified were routinely discussed at the complex patient meetings.
- An interpretation service was available for patients who did not have English as a first language. The practice leaflet was available in other languages for patients who did not have English as their primary language.

Privacy and dignity

- All patients who responded to the regional-wide patient survey rated the practice as either excellent or good for ensuring privacy and dignity. Equally, patients interviewed as part of this inspection said their privacy and dignity was maintained during consultations.
- At the previous inspection, privacy screening was not available in a number of clinical rooms to maintain the privacy and dignity of patients during intimate examinations or procedures. We observed appropriate mobile screening in these consultation rooms. Tracking for privacy curtains was due to be installed as part of the refurbishment to start in August 2021.
- Patient consultations took place in clinic rooms with the door closed. Headphone sets were used for telephone consultations. If a patient presenting at reception was distressed or wished to discuss a sensitive issue, they had the option to talk with a member of staff in a private area.
- The SMO and the practice manager were the leads for patient information management, including confidentiality of clinical records. The staff team had received training in information governance.
- The practice had a sufficient mix of male and female clinicians to accommodate patients who may wish to see a clinician of specific gender.

Are services responsive to people's needs?

We rated the practice as good for providing responsive services.

Following our previous inspection, we rated the practice as good for providing responsive services. However, we made a recommendation to ensure compliance with the Equality Act 2010.

At this inspection we found the recommendations we made had been actioned.

Responding to and meeting people's needs

- The 2021 staff climate survey strongly focussed on equality with 80% of respondents indicating that the practice took account of the principles of equality in the workplace.
- The practice was pro-active with ensuring it took account of the Equality Act 2010 when responding to the needs of individual patients. For example, staff requested a talk/training through the military LGBT+ network to better understand the difficulties faced by transgender patients and how the practice could improve the service provided. The training took place in February 2021 and covered healthcare needs and the use of pronouns. As a result, the practice developed an SOP around asking about preferred pronouns.
- Through patient feedback and from discussions with staff, we identified that staff clearly understood the specific health needs of transgender patients. Monitoring, including for patients prescribed high risk medicines, and screening services were routinely offered. Patient feedback highlighted that staff were caring, empathic and comfortable with engaging in sensitive discussions. The practice had sourced booklets on screening information for transgender people from Public Health Wales.
- In response to a 2020 medical journal article regarding the risk for black, Asian, and minority ethnic (BAME) people contracting COVID-19, the practice carried out an audit. It identified that 25% of the patient population were from ethnic minority groups. The practice decided to lower the threshold for the over 40s check to over 25 for the BAME population. Patients who were not already being managed through existing screening and review programmes were invited in for a full health screen. This meant a full health screen took place for the BAME population. This work was reported as a quality improvement project.
- An equality access audit for the building (which includes the PCRF and co-located dental centre) had been completed in September 2020 and reviewed again in May 2021. Work to make the building more wheelchair accessible was due to take place as part of a refurbishment in August 2021. This work included a lowered reception counter, automatic opening front doors and a pull cord in the accessible toilet. The audit did not identify the need for a hearing loop. We were advised this would be kept under review through an annual repeat of the equality access audit or more frequently if the population changed.
- The practice responded to feedback from patients. For example, feedback indicated patients were either not keen on the e-Consult approach or were unaware of it. In

response, the practice promoted e-Consult through leaflets, posters and training for patients in the use of e-Consult. The virtual patient focus group held May 2021 requested a text information and reminder service. This had been put in place for sharing information, such as bank holiday cover arrangements and how to access the patient survey.

- When a COVID-19 outbreak was identified at the camp, practice staff facilitated testing/swabbing on a Sunday afternoon within two hours of notification by the unit. A rapid turnaround of results allowed appropriate isolation and contact tracing to occur in a timely way.
- Changes to working practices due to Covid-19 were advertised through a variety of means including the text message system and information circulated to units.

Timely access to care and treatment

- In response to restrictions associated with COVID-19, the practice had fully integrated the use of e-Consult to reduce the number of people accessing the medical centre. Face-to-face consultations were offered if clinically required. Outreach COVID-19 clinical support offered by SMO and SNO to the Infantry Battle School during the pandemic. A home visit SOP was in place. We were advised there was minimal demand for this service.
- A duty nurse clinic was held each morning for patients requiring an urgent appointment. A duty doctor was available should the nurse need to refer the patient on. The practice was flexible and could respond to patients presenting outside of the emergency clinic times. Routine appointments were available within two days with a doctor or nurse. Access for vulnerable patients was prioritised. The physiotherapist offered direct access appointments and had time dedicated specifically for students on career courses. Pre-course, routine or discharge medicals had a wait of less than one week.
- The practice provided its own out of hours cover using a duty clinician who could be contacted via a duty mobile phone. The number was circulated through the practice leaflet, on the answerphone message and on the door of the medical centre. Seventy nine per cent of patients who responded to the regional patient survey were aware of how to access the service out of hours. Equally, patients we interviewed as part of this inspection were aware of the process.

Listening and learning from concerns and complaints

- The practice manager was the lead for complaints, which were managed in accordance with the DPHC complaints policy and procedure. Written and verbal complaints were recorded on the complaints register and discussed at the practice meetings. The last complaint was received in May 2019.
- Patients were made aware of the complaints process through the practice information leaflet and posters in the waiting room. There was also a comments books in the waiting room. Eighty seven per cent of patients who responded to the regional patient survey said their comments and complaints about the service were listened to.

Are services well-led?

We rated the practice as good for providing caring services.

Following our previous inspection, we rated the practice as requires improvement for providing well-led services. We identified shortfalls in governance arrangements and the overall leadership of the service.

At this inspection we found the recommendations we made had been actioned.

Leadership, capacity and capability

- The leadership team had changed since the last inspection. The SMO, SNO and practice manager had taken up post within the last 12 months. They worked well together and demonstrated high levels of experience, capability and resourcefulness to deliver responsive and sustainable care to the patient population.
- The collaborative leadership approach between the SMO, SNO and practice manager meant the smooth running of the practice was not dependent on any one individual. For example, the SNO had assumed the role of clinical lead while the SMO was deployed abroad until October 2021. Despite being absent from the service, the SMO maintained contact with the practice, including participation with this inspection. All the staff we spoke with were pleased with the leadership of the practice and they particularly commented on how the service was more structured.
- The leadership team described good support from the regional team. A regional health care governance visit took place in May 2021. The practice received positive feedback about the leadership of the service and the changes made.

Vision and strategy

- Throughout the inspection it was clear staff were committed to providing and continually developing a service that embraced the mission, values and vision. The practice worked to the following DPHC mission statement:

  > "Provide and commission safe and effective healthcare which meets the needs of the patient and chain of command in order to contribute to fighting power."

- At local level, the practice aimed to:

  > "Deliver excellent primary care and support the chain of command to improve the physical and mental health of our patients in all supported units across South Wales"

- We found that services were designed to meet the needs of the local populations with rapid and flexible access to care for both Infantry Battle School personnel (students and staff) and users of the local training area. The practice's response to a Covid-19 outbreak was an example of this rapid and flexible service access.

- The practice was part of a GP Remote Support (GPRS) network for the south Wales group. Underpinned by a SOP, the aim of the GPRS was to form a communication network between the six medical centres in the group. Objectives of the network included strengthening service resilience during times of staff shortage, sharing best practice and the use of collaboration as a means promote collective development. Brecon Medical Centre was identified as the hub practice for the network. At the time of the inspection the practice was providing significant support to another practice within the network that was short of clinical staff.

Culture

- Staff described an approachable and supportive leadership team that was committed to ensuring equality and inclusion within the staff. It was clear staff and their contributions were valued. All staff attended the practice meetings provided a supportive environment to put forward suggestions or raise concerns.
- Staff said there was an open-door policy with everyone having an equal voice, regardless of rank or grade. All were familiar with the whistleblowing SOP which was reviewed in October 2020. We were provided with examples of when staff had used the whistleblowing policy. Staff also had access to the Freedom to Speak Up (FTSU) process with three regional FTSU champions known to the practice.
- A responsive and patient-centred focus was clearly evident with this ethos embedded in practice. Staff continually looked at ways to improve the service for patients.
- Processes were established to ensure compliance with the requirements of the duty of candour, including giving those affected reasonable support, information and a verbal and written apology. The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment. The practice maintained a duty of candour log on the healthcare governance (HCG) workbook and recent examples of where duty of candour had been applied had been recorded.

Governance arrangements

- Since taking up post the SNO had undertaken a review of governance systems and revised the whole system. We found that the governance framework was effective to support the delivery of good quality care. The HCG workbook had been effectively developed to capture and monitor governance activity. All staff had access to the workbook which provided links to meeting minutes, policies and other information.
- There was a clear staffing structure in place and staff were aware of their roles and responsibilities, including delegated lead roles in specific topic areas. All roles had cross cover to take account of absence management**.** Terms of reference were in place to support job roles, including lead roles for specific areas.
- Formal communication channels had been strengthened. A schedule of regular practice, complex patient, governance and management meetings was established. Minutes showed the meetings were well attended.

- A programme of quality improvement activity (QIA) was established to monitor the outcomes and outputs of clinical and administrative practice. The leadership team supported staff to put forward ideas and engage with QIA. This was evident during the inspection such as the audit in relation to COVID-19 risks for the BAME population.

Managing risks, issues and performance

- There was an effective process to identify, understand, monitor and address current and future risks including risks to patient safety. Risks to the service were well recognised, logged on the risk register and kept under scrutiny. The risk register and issues log for the practice were reviewed at the management meeting each month. The framework of risk assessments were reviewed every six months.
- Processes were in place to monitor national and local safety alerts, incidents, and complaints. The business continuity plan was reviewed in May 2021 and included a detailed section about responding to a pandemic.
- The leadership team was familiar with applying policy and processes for managing under-performance and ensuring staff were supported in an inclusive and sensitive way taking account of their wellbeing.

Appropriate and accurate information

- The eCAF (Common Assurance Framework) was commonly used in DPHC services to monitor performance. It is an internal quality assurance governance assurance tool to assure standards of health care delivery within defence healthcare. The practice was not using the eCAF at the time of the inspection due to proposed migration to a new organisational system. As an interim measure, the practice was using the CQC's key line of enquiries (KLOE) framework to monitor performance.
- National quality and operational information were used to ensure and improve performance.
- Systems were in place that took account of data security standards to ensure the integrity and confidentiality of patient identifiable data, records and data management.

Engagement with patients, the public, staff and external partners

- There were various options in place to encourage patients to provide feedback on the service and contribute to the development of the service. Due to COVID-19, options for patients to provide feedback while visiting the practice were limited, including use of the comments book in the reception. Patients had the option to provide feedback on the service through the patient survey. A patient participation forum was established and meetings were taking place virtually. The outcome of collective patient feedback was displayed at the practice, including how the practice had responded.

- Good and effective links were established with internal and external organisations including the welfare services, mental health services, local health boards and local NHS providers.

Continuous improvement and innovation

We identified that significant improvements had been made to the service since the last inspection. The change in leadership team clearly had had an impact as there was evidence of a revision of the governance structure, innovative practice and improvements being made, including quality improvement projects. The following is a summary some of the improvements we identified:

- Based on a high risk for the patient population, the practice provided heat injury training for local NHS services.
- The practice demonstrated a commitment to meeting the principles of the Equality Act 2010, including safeguarding people with protected characteristics from discrimination. For example, the age over the over-40 health screen was lowered for the BAME patient population because of recognised risks associated with COVID-19.
- The practice was responsive the needs of patients demonstrated through, for example, clinicians facilitated testing on a Sunday afternoon within two hours of notification when a COVID-19 outbreak was identified at the camp.
- The practice secured funding for an NHS laptop so clinicians had timely access to hospital records for their patients, including the status of urgent referrals, pathology results and the results of scans.